PRE-PROPOSAL MEETING

FOR

UTILIZATION CONTROL OF SELECTED HOSPITAL, NURSING FACILITY, AND HOME AND COMMUNITY BASED SERVICES REIMBURSED BY THE MARYLAND MEDICAID PROGRAM

CONTRACT NO.: DHMH-OPASS-16-14617

JULY 28, 2015
201 West Preston Street
Room L-3
Baltimore, Maryland

9:00 p.m. - 10:10

PRESENT FROM DHMH:

SABRINA LEWIS, Procurement Administrator

QUEEN DAVIS, Procurement Specialist

JANE SACCO, Office of Health Services

MARYAM BAHARLOO, Chief, Division of Hospital Services

SUSAN PANEK

DAWNN WILLIAMS

MARLANA HUTCHINSON

SUSAN TUCKER

DENISE JAMES

GLENDORA FINCH

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PAUL GRAVES

MONCHEL PRIDGET

JILL SPECTOR

ALSO PRESENT:

LEONARD G. TOKAR, Avysion

LEONARD TOKAR, Avysion

ERNEST SODEN, III, La Madrid Enterprises

DORIAN EDWARDS, Support Network

ANN KENNY, Telligen

BRYAN DORSEY, Livanta

MARIA CASCHETTA, Livanta

KIRK GROTHE, Livanta

JOSEPH CONLEY, JR., SQN Systems

JANET ROBINSON, Delmarva Foundation

LINDA OLIVER, Delmarva Foundation

DIANE GULLO, Quality Health Strategies

HERB SMITH, The Grant Group

S. ORLENE GRANT, The Grant Group

TUESDAY WILLIAMS, Taki Medical Consultants

BRITTANY HELLREICH, Maximus Federal

BILL BYRD, Business Promotion Consultants

KAREN SMITH, Advanta Medical Solutions

REPORTED BY: KATHLEEN A. COYLE, Notary Public

P R O C E E D I N G S

MS. LEWIS: My name is Sabrina Lewis and I'm the Procurement Coordinator. What I'm going to do is basically do introductions. Again, Sabrina Lewis, Procurement Coordinator.

MS. DAVIS: Good morning. My name is Queen Davis. I'm the Contract Officer for this procurement.

MS. SACCO: Jane Sacco, Division Chief, Long Term Care. I'm also contract monitor.

MS. PANEK: Susan Panek, Deputy Director for Long Term Care Programs for Medicaid.

MS. BAHARLOO: Maryam Baharloo, Division Chief, Division of Hospital Services.

MR. TOKAR: Leonard Tokar, Avysion Healthcare Services.

MR. SODEN: Ernest Soden, La Madrid Enterprises.

MR. EDWARDS: Dorian Edwards, Support Network.

MS. KENNY: Ann Kenny, Telligen.

MR. GROTHE: Kirk Grothe, Livanta.

MR. DORSEY: Bryan Dorsey, Livanta.

MS. CASCHETTA: Maria Caschetta, Livanta.

MR. WISZNEWSKI: Anthony Wisznewski (phonetic), Livanta.

VOICE: (Unintelligible)

MS. DAVIS: In the back, madam?

MS. OLIVER: Linda Oliver, Delmarva Foundation.

MS. ROBINSON: Janet Robinson, Delmarva Foundation.

MS. GULLO: Diane Gullo, Quality Health Strategies.

MR. CONLEY: Joseph Conley, SQN Systems.

MR. SMITH: Good morning. Herb Smith, The Grant Group.

MS. HELLREICH: Brittany Hellreich, Maximus Federal.

MS. WILLIAMS: Tuesday Williams, Taki Medical Consultants.

MS. DAVIS: In the back?

MS. JAMES: Denise James.

MS. FINCH: Glendora Finch, Quality Assurance.

VOICE: John (Unintelligible), Supervisor of Medical Assistance Transportation.

MS. HUTCHINSON: Marlana Hutchinson, Medicaid.

MS. WILLIAMS: Dawnn Williams, Medicaid.

VOICE: Susan (unintelligible), Medicaid.

MR. BRIGGS: Paul Briggs, (nintelligible) Information Systems.

MS. PRIDGET: Monchel Pridget.

MS. DAVIS: Okay. Thank you. Hopefully everyone had a chance to sign in. And if you haven't before you leave can you sign in on the sign in sheet back there as well as there's an envelope to leave your business cards.

So we're going to start this with Queen Davis who will go over the procurement aspects of the RFP.

MS. DAVIS: Good morning again, and thank you for coming. I would like to just encourage you all that once the question and answer portion starts if you

would please kindly state your name and the company you're with, and state it loudly and clearly so that our transcriber can capture that information. There's some background noise and that kind of like messes with the sound. So I would appreciate that.

Again, my name is Queen Davis. I'm the contract officer for this procurement, and I'm here to help you understand the procurement process. DHMH Office of Health Services has issued this RFP to contract with a vendor for the provision of utilization control services and selected hospitals, nursing facilities, and home and community based services that are covered by the Maryland Medicaid Assistance Program as described in the scope of work on section three, beginning on page 31 of this RFP.

Minutes will be taken of this meeting and will be distributed to everyone in attendance, and to everyone known to have received a copy of this proposal. If you decide not to submit a proposal we ask that you complete and return the vendor information form, page ii, of the RFP. It's entitled notice to

vendor form, which is feedback response that could be helpful in planning the Department's future procurements.

Subsequent to this preproposal conference written questions will be accepted until there is insufficient time to do so before the due date of the proposals. Also, questions and answers will be distributed to all vendors known to have received a copy of this proposal. Questions and answers as well as minutes from this proposal will also be posted on eMarylandMarketplace and DHMH's website. Please remember that in order to receive a contract award a vendor must be registered on eMarylandMarketplace. Registration is free. Please review subsection 1.9 for details and website addresses.

Questions regarding this proposal should be submitted no later than five business days prior to proposal due date. The procurement officer, Michael Howard, who is a part of -- who I am representing as part of Office of Procurement Support Services, based on the availability of time to research and communicate

an answer, shall decide whether an answer can be given before the proposal due date. So try to get any questions to us as soon as possible.

The contract resulting from this solicitation will be for three years, beginning on or about January 1. And -- I'm sorry, February 1. And there are two one-year renewal options. The procurement method for this solicitation is competitive sealed proposals.

Section two lists the offeror minimum qualifications. And that's on page 30. There are three minimum requirements listed. If minimum qualifications set forth in the RFP are not met, the offeror's proposal will be rejected and will not be evaluated further.

Offerors are required to submit their responses to the RFP in two parts. Volume one is the technical proposal in a separately sealed envelope, and volume two, your financial proposal that is also to be submitted in a separately sealed envelope. Each envelope shall bear the RFP title and number, name and

address of the offeror, and closing date and time for receipt of the proposal. Pages of both volumes shall be consecutively numbered. The general format for this proposal is clearly stated in section four, proposal format. A brief transmittal letter prepared on the offeror's letterhead, and signed by someone who is authorized to commit the offer to the service and requirements of the RFP is requested. Be sure to include your federal employer ID number or your Social Security number. Please acknowledge any addenda. And if applicable, please include your **email** address.

Subsection 4.4 lists all of the documents and information required to be submitted with volume one, which is your technical proposal. And please give special attention to subsection 4.4.2, which lists additional required technical submissions.

There is a 27 percent MBE goal established for this contract. And for MBE information please refer to subsection 1.33 in section one of this proposal.

Be sure to complete your MDOT certified MBE

utilization and fair solicitation affidavit with your attachment D1. This attachment must be provided in a sealed, separate envelope. If an offeror fails to submit attachment D1 with the offer as required the procurement officer shall deem the proposal non-responsive and shall determine that the offer is not reasonably susceptible of being selected for award. So I urge you to please complete the D1 completely, and clearly, and accurately. If that form is not submitted with your proposal you will be found not reasonably susceptible and your financials will be returned to you unopened.

A VFBE contract participation goal of one percent of the total contract dollar amount has been established for this procurement also. And please see section 1.41 for instructions and information on the VSBE participation goal.

The following number of technical proposals are required. We require one unbound original and six copies of your technical proposal. One electronic version in Microsoft Word format is also required. And

a second electronic version in searchable PDF format for Public Information Act is required. This copy shall be redacted so that confidential and/or proprietary information has been removed. Volume two is your financial proposal that is also in a separately sealed envelope, and shall contain all price information in the format specified in attachment "F." The number of copies for volume two, financial proposal, is one unbound original, six copies, one electronic version in Microsoft Word of the financial proposal is also requested or required.

Your proposal will be evaluated by a committee organized for this purpose and will be based on the criteria set forth in the RFP under section five, evaluation criteria and selection procedure, beginning on page 49 of -- I'm sorry, beginning on page 77 of this RFP. The technical criteria is listed in descending order of importance and can be found in subsection 5.2, which is page 77. And the financial criteria is listed in subsection 5.3, and that can be found on page 78 of the RFP.

As noted in subsection 5.5, under selection procedure on page 79, the contract will be awarded to the responsible offeror that submits a proposal determined to be the most advantageous to the State considering technical evaluation factors and price factors as set forth in the RFP. Unsuccessful offerors have the right to ask for a debriefing.

Upon completion of the technical proposal and financial proposal evaluations and rankings each offeror will receive an overall ranking. And for the purpose of this solicitation in making the most advantageous proposal determination, technical factors will receive greater weight than the financial factors.

Within five days of being notified of its recommendation for award the offeror must complete and submit the contract affidavit set forth in attachment "C." If there is a question as to who your resident agent is please contact the State's corporate charter division at (410) 767-1330. And the office is located at 301 West Preston Street. Please note that the contract shall not become effective until the contract

affidavit is signed and returned after official notification.

It is very important that you get your proposal to us by the date, time, and location listed in the proposal. Your proposals are due no later than Wednesday, September 9, 2015, at 2:00 p.m. local time. The address for receipt of proposals is listed on the key information summary sheet, which is page iii. And no proposals will be accepted after the specified due date and time.

There are three acceptable means of delivering a proposal. One is by U.S. Postal Service, two is hand-delivery by offeror. Please ask for a receipt when you bring your proposals to our office, and make sure that someone signs and date and time stamps your proposal. And also by hand-delivery of a commercial carrier. And make sure your commercial carrier asks for a receipt.

And now I'll turn it over to Ms. Jane Sacco, who is a program and will give you an overview of the long-term care.

MS. SACCO: Okay. In your proposal the long-term care part starts on page 44 of Baltimore State Hospital Section 3.2.5. And I'm just going to give a brief overview. And as I go through you'll see, you know, a lot of commonality. The purpose of the long-term care review is to ensure that services we're providing people for these services, for these programs, you know, are medically necessary, that they meet the criteria for the program, even at the beginning, both at the beginning and, you know, throughout their participation in the program.

So for the longer stay hospitals that includes adult chronic hospitals and special pediatric hospitals of which three are currently enrolled in the program. For those programs the contractor will be performing initial medical eligibility review to determine whether or not, you know, those services are medically necessary. Also, a continued stay review if the individual is found to be eligible for the services, you know, gets Medicaid eligibility, continued stay review periodically to ensure that they

continue to meet the criteria medically for those services.

In addition to the chronic and special pediatric we also have nursing facility reviews, which starts on page 47. And with these reviews you are also doing an initial medical eligibility review to determine whether or not the person meets what we call a nursing home level of care. Periodically after that, once the person is in a facility, the review looks at whether or not they continue to meet the criteria. In addition, unique to nursing facilities, the contractor will be performing follow-up reviews to make sure that the federal requirements under pre-admission screening and resident review, also known as PASAR, that the facility has met those requirements for anyone who would need such a review.

Also, just to go back, in addition to these reviews you're also doing follow up services such as, if someone does not meet the criteria for binding a legal notice to the individual, their next of kin or guardian with their appeal rights. Also, to the extent

that they may require services after they've been found to no longer need those services and they're looking for a discharge, there are what we call administrative days. And the contractor is looking to see if those requirements are met.

Also, for the nursing home, the contractor will be doing a sample review of the MDS document, minimum data set, which is the federally designated instrument for nursing homes for assessing their residents for the purposes of determining whether or not the reimbursement is appropriate under our (unintelligible) system, which began January 1st.

For the home and community based services you'll notice we break that out into two separate sections, primarily because under some home and community based services the contractor will be using our long-term service and supports tracking and for others, you know, you'll be required to have a system that meets the requirements of this RFP. But anyway, for -- the first group consists of the medical adult daycare, the brain injury waiver, community options

waiver, which is a combination of what was once known as the waiver for older adults and the living home waiver, the community supports program, community first choice, and the community personal assistance services, which you may also know as medical assistance personal care. For that program you're doing, again, a medical eligibility review at the beginning of their enrollment or their application to the program. There's also an annual requirement for a medical eligibility review.

In addition, you're also doing a validation of the auto approval process in the LTSS. There is a process by which individuals who readily meet their requirement for the level of care are automatically approved by an algorithm that we've set up. And one of the contractor's duties is to review a sample of those which is provided by the department to see whether or not they agree with that determination.

In addition, the contractor will be doing in-home assessments for the people in these programs that I just mentioned, the daycare, community options, the community first choice, and the C-pass to determine

what their needs are.

Do you want to add anything about the adult daycare?

MS. PANEK: No. The principal is the same in both the case of daycare, the medical adult daycare program. AERS actually, the adult evaluation and review services units on the local health departments perform an initial review. And UCA gets involved if that initial review is supposed to be a denial, because then it would go to UCA's medical director in that case. And then the UCA also would be reviewing continued stay review.

In the case of the brain injury waiver, there are specific criteria for both the chronic hospital level of care and the nursing facility level of care in the brain injury waiver. And the people who actually are the program directors, the behavioral health administration and department, are in this process of developing their own instrument that is specific to brain injury. That's probably at least a year away, but they are developing a brain injury specific

evaluation instrument that will ultimately be implemented. That's pretty much it.

MS. SACCO: Okay. All right. And then starting on page 53 are requirements for the model waiver program and program of all-inclusive care for the elderly, also known as PACE. We have a PACE site in Maryland. And for those programs the contractor will be performing a medical eligibility review in the beginning to determine whether or not the level of care criteria are met. And also annually for the model waiver an annual review is conducted. Now, for the PACE review -- and this is PACE only, no other program -- a single redetermination is done one year following the initial medical eligibility review. After that the participants deemed to need the level of services and no more review is required.

Okay. On page 54 we're also having the contractor, this is something new, doing preauthorization of selected durable medical equipment to determine whether or not, essentially, the particular equipment in question is medically

necessary. In addition to doing the review, the contractor will be responsible for sending out the notice of any adverse determination with the person's appeal rights.

And then finally, under the big umbrella of long-term care and community support is retrospective review of air ambulance services, reviewing submissions for payment of air ambulance service and determining whether or not the transport was medically necessary, and taking into account the individual's condition, the mode of transport, where they're being transported, et cetera. And that's pretty much it for the long-term care and community support.

I did want to touch on something Susan touched on briefly. That for any reviews under these cases or a pending denial, you know, there is a requirement for a physician review. Do we break for questions or --

MS. DAVIS: Yes.

MS. SACCO: Okay. Any questions?

MS. CASCHETTA: Hi. Maria Caschetta from

Livanta. Just on the physician review is there a requirement for the physicians to be actively practicing medicine? I noticed a physician provides us the medical record.

MS. SACCO: For long-term care and community support is there -- the question is, is there a requirement that they be actively practicing? No.

MS. PANEK: They have to be licensed.

MS. SACCO: Yes. They have to be licensed.

MS. CASCHETTA: Another question. There are -- may I ask questions about the contract terms and conditions or just --

MS. DAVIS: Absolutely. Yes, ma'am.

MS. CASCHETTA: There is a contract term and condition regarding liability for non-performance under the contract.

MS. DAVIS: What page?

MS. CASCHETTA: On RFP Section 3.28, page 56. And it says that essentially you're responsible for direct and consequential damages if CNS, basically wants to take back money for the (unintelligible) will

be the liability of the contractor if it was due to non-conformance. And non-conformance can be interpreted as making a bad decision or not interpreting something properly. Is it your intent, is it the intention of the State to keep this in here as a requirement under the contract?

MS. DAVIS: At this time it is.

MS. CASCHETTA: I just wanted to offer the suggestion that there is no -- business liability insurance will not cover this for a contractor. And this will be considered something that would be a definite deterrent from competition for people being willing to do the work under the contract. There are no federal contracts that have this, that are imposed with QIOs or QIO entities, like entities. I just wanted to share that because I understand that you do want QIO or QIO like entity to provide these services.

MS. DAVIS: So this is one of the determinations of the program. At this time it will be left. They can certainly discuss it. And if a change is going to be made we can do that via an addendum

prior to proposal due date and time. But at this time it is part of the proposal.

MS. CASCHETTA: Okay. Thank you very much.

MS. DAVIS: You're welcome.

MR. DORSEY: Bryan Dorsey from Livanta. What is the value of the incumbent contract; is the contract annually?

MS. DAVIS: I can give you, and I didn't bring it with me, but I will give you a total contract dollar amount, and the contractor's name as part of the minutes.

MR. DORSEY: Additional question, sorry. We are a federal QIO, and you asked for a certification as part of the RFP. Would copies of our contract as a QIO be acceptable as a minimum requirement. We don't have a certification because we're not --

MS. DAVIS: If it's asking for certification I am assuming that a certification document is required. I can be more specific on that question once I confer with the -- yes, ma'am.

MS. CASCHETTA: Just to piggy backing on that.

MS. DAVIS: Okay.

MS. CASCHETTA: The federal government doesn't give you a certification that you're a QIO. You just are a QIO.

MS. DAVIS: Okay.

MS. CASCHETTA: So when you're considering that maybe you might look for evidence of proof that the organization has been, is recognized as a quality improvement organization.

MS. DAVIS: Well, we'll consider what the federal government do require, and then we will look for the proof. But I will give you a more definitive answer in the minutes. Thank you.

MR. DORSEY: In section 3.2.1.9 on page 33 --

THE REPORTER: Could you keep your voice up, please.

MR. DORSEY: I'm sorry.

MS. DAVIS: Yes.

MR. DORSEY: Section 3.2.1.9 on page 33 talks about reviews being conducted at both ICD9 and ICD10. Is it the intent of the State for that to mean

consistent with the ICD9, ICD10 transition date or is it expected that there will be some dual reviews using both of those for some State requirement?

MS. BAHARLOO: I would say it would be for the transition (unintelligible) ICD9 that they need to have capabilities of both.

MR. DORSEY: Just the capabilities?

THE REPORTER: I can't hear her.

MS. DAVIS: Can you speak up, please.

MS. CASCHETTA: When he's saying dual reviews, there is a possibility that the same case could be reviewed under nine and 10 depending on if the contractor has submitted something under, it includes both code sets which no one would like to have happen, but I think it may happen because there's difficulties with the physician providers and other types of providers whether they're ICD10 limitations that I'm aware of right now. So they're anticipating significant issues around the first of October that extends to the end of the year. So I would assume that some of the staffing levels may actually have to be

higher than historical levels because of ICD10s.

MS. BAHARLOO: We're going to have to look into this. We're going to have to let you know if there will be a dual --

MS. PANEK: We are planning to implement our total --

MS. BAHARLOO: Yes.

MS. CASCHETTA: There is a transition period. It says start up period. Is the transition period considered to be the start up period; is that the same term?

MS. DAVIS: It's not the same term. The start up period is the date that the contract begins. Transition period is the time between award notification and the actual contract start date.

MS. CASCHETTA: Well, it says under the contract that there will not be payment for services during the start up period.

MS. DAVIS: During the transition period, right.

MS. CASCHETTA: Okay. So that's a 90-day

start up period?

MS. DAVIS: There will not be a payment during that time because the contract is not executed until February 1. However, I am assuming that your initial check will be a larger one to include that time.

MS. CASCHETTA: That was my question. So you're basically saying that although compensation won't be made during --

MS. DAVIS: During the transition period. You will be --

MS. CASCHETTA: You can submit a bill for that after?

MS. DAVIS: Yes, ma'am.

MS. CASCHETTA: Would you consider, please, like just clarifying that?

MS. DAVIS: Sure.

MS. CASCHETTA: If the organization, the utilization control agent is owned by two companies, two companies, it's 50 percent owned by two different organizations, and one of those organization is an

owner and has relationships with providers in the area, is there a mitigation plan that would allow the subsidiary company to provide services under this contract? Is it acceptable to put in fire walls to perform the services or would that be considered a conflict of interest?

MS. DAVIS: It appears that it is indeed a conflict of interest. I would have to actually talk to legal, or maybe Susan can answer that. It's not?

MS. PANEK: We need to talk to legal.

MS. DAVIS: Okay. We need to talk to legal.

MS. CASCHETTA: Can we submit a question?

MS. DAVIS: Submit a question to that affect and we will answer it specifically. Yes.

MS. CASCHETTA: I'm assuming -- I've looked over this. You're not really -- you're requiring the use certain software under the contract, like the LSSS. But to perform the services under the contract can the contractor use its own systems, its own practices, et cetera, to provide the services or are they specific State systems that you want everything entered into?

MS. SACCO: I can answer that. For certain programs it has to be done through the State system. And those programs are the adult daycare, brain injury, the community options waiver, the community first choice, we call them community services, and the community personal assistance services. Have I left anything out?

(No response.)

MS. SACCO: Okay. Because they are set up on ours. The other ones, the nursing homes, the longer stay hospitals, the model waiver, the PACE you can do through your system.

MS. CASCHETTA: Okay.

MS. LEWIS: Anyone else have any questions?

MS. KINNEY: We have a question on C-2-2.B.C on page 34. It says the RFP requires two full time physician advisors. Can this requirement be met by the bidder applying for half-time physician advisors rather than full time physicians?

MS. BAHARLOO: No. Because two physicians are required for long-term care and for --

MS. SACCO: Two full time.

MS. BAHARLOO: Right.

MS. KENNY: Okay. Thank you.

MR. DORSEY: What is considered full time? Is there an hourly requirement for that?

MS. SACCO: It's defined in here somewhere, full time. I believe it's 40 hours a week but I'd want to go back and check.

MS. CASCHETTA: I believe what he's asking is there are 1880 hours and there are 1920 in a full time year, depending on the level of leave that a contractor gives to people. So if there is essentially full time, which would mean like 1880 where you're given two weeks vacation, et cetera, or is there a true full time, meaning someone has got to be there every day of the week, in which case would be more than one person fulfilling that role. Because nobody works 40 hours every single week of the year.

MS. DAVIS: In section one of the RFP, letter AA, on page nine of the RFP, it describes full time employee as an employee or combination of

employees who work 40 hours per week. So it's one employee or a combination of employees that's working the 40 hours per week.

MS. CASCHETTA: Okay. So then essentially it's a 2080 hour equivalent?

MS. DAVIS: Yes.

MS. CASCHETTA: Okay. In which case, then going back to her question about physician advisors, you're really talking about more than one doctor because one doctor cannot work 40 hours every single week. They work, you know, they take off. They have holidays, et cetera. So and you have a 24/7 operation.

MS. DAVIS: Yes.

MS. CASCHETTA: So you really need people covered during your holidays. So that would be essentially the equivalent of two, of a full time FTE as you described, 2,080 hours?

MS. DAVIS: Yes.

MS. CASCHETTA: Okay. That would be helpful if that was in the requirements spelled out.

MS. DAVIS: But the abbreviations and

definitions does list what full time employee -- you want it to say specifically?

MS. CASCHETTA: You know, if that means literally 40 hours every week, then that's fine.

MS. DAVIS: It means literally -- yes, it means literally 40 hours per week.

MS. CASCHETTA: Thank you.

MS. DAVIS: You're welcome.

MS. LEWIS: Anyone else?

(No response.)

MS. GRANT: Orlene Grant from The Grant Group. You call for three managers in different areas?

MS. SACCO: Yes.

MS. DAVIS: What section are you in?

MS. SACCO: Yeah. That's on page 34. Yes. One dedicated to the acute care, one dedicated to non-acute care, your longer stay hospitals, nursing facilities, and the home community based, and the third dedicated to the home and community based, the in-home service assessments.

MS. GRANT: Do all three of them need office

space or can one be based in the community?

MS. SACCO: Can you just go more into what you mean by based in the community?

MS. GRANT: Well, they don't come into the office all the time, but they are based from their home into the community or into the nursing home; do all three need to be office based?

MS. SACCO: I think we envision them being office based. I don't think we spell it out there specifically.

MS. PANEK: Can you submit it as a question?

MS. DAVIS: Yeah. Just submit the question and then we'll answer it. And that also becomes part of the requirements of the RFP.

MS. GRANT: And you feel they need to be?

MS. DAVIS: She said that they need to be office based.

MS. SACCO: We envision, but I don't know that we specified that.

MS. CASCHETTA: In section 3.2.2.1 you say the office has to be 40 miles of -- the managers at a

minimum, the nurses have to be based out of that office, right?

MS. DAVIS: Yes. 3.2.2.1, office location and staffing requirements.

MS. LEWIS: Any additional questions from anyone?

MS. CASCHETTA: Just one other thing. On the full time equivalent. When we get into the full time managers, again, we're going to have a similar issue, you mean essentially full time, but with their leave considered versus you want real coverage for 40 hours in every week and that's more than three full time managers?

MS. DAVIS: So you're referring to number "D" under section 3.2.2, where it sways three FTE managers?

MS. CASCHETTA: Yes. But then when it defines full time equivalent it says 40 hours a week.

MS. DAVIS: It says 40 hours a week?

MS. CASCHETTA: Yes. So the 40 hours a week generally from that scenario with full time equivalent

it means, you know, less holidays, vacation, you know, et cetera. If you really mean 40 hours a week that's more than three people because you have to give people leave. You know, you might --

MS. DAVIS: We can clarify that later.

MS. CASCHETTA: Okay. Thank you.

MS. DAVIS: Thank you.

MS. GRANT: Going back to my original question, 3.2.2.1, you call, page number 34, you call for two full time managers in the office, but you have three FTE managers listed in "D" under 3.2.2.3. So is that how you're equating that you have two full time?

MS. SACCO: Actually, that should be the three. We'll correct that. We're actually looking more into your question, but I think that was more of an error.

MS. DAVIS: Yeah. That should be three and then three full time managers and two full time physician advisors.

MS. CASCHETTA: I have a security related question for IT. Are you going -- I noticed you have

requirements in here for encryption of all data at rest and in transit. Is anybody from the State going to come out and review contractor systems for compliance or is this something that's self certifying?

MS. DAVIS: I think that's part of your self certifying.

MS. CASCHETTA: Self certifying?

MS. DAVIS: Yes.

MS. KINNEY: Back to the office location and staffing requirements. Does the State expect the IT director specified in the RFP to be devoted 100 percent to the contract?

MS. SACCO: Yes. Uh-huh.

MS. KINNEY: Okay. Thank you. What is the volume of certification process for specialty pediatric hospitals?

MS. SACCO: What page is that?

MS. KINNEY: It is page 47, B22.5.2.B

MS. SACCO: Okay. "B," continued stay review for special pediatric?

MS. KINNEY: Uh-huh.

MS. SACCO: What was your question?

MS. KENNY: What is the volume?

MS. SACCO: The projection should be in the back, in one of the appendices, page 210. It starts on page 210, annual estimates.

MS. DAVIS: Annual estimates.

MS. SACCO: Right. Yes. Fifteen hundred.

MS. PANEK: That's just --

MS. KINNEY: Those are the special pediatric hospitals?

MS. DAVIS: Right.

MS. KINNEY: What organization face-to-face encounters relationship of the participants health status to the prescribed DMP?

MS. SACCO: What page is that?

MS. KINNEY: Page 57.

MS. SACCO: Can you speak up a little? And if you have a question if you could give the page, please.

MS. KINNEY: Okay. Sure. It's 3.2.7.3.A1C, page 57.

MS. SACCO: Okay. Mine came out as page 54.

And what was your question again?

MS. KINNEY: What organization completes the face-to-face encounters (unintelligible) relationship of the participant's health status to the prescribed DMP?

MS. SACCO: I believe that's the health care professional that ordered the equipment. Am I -- is there anybody here that can confirm that?

(No response.)

MS. PANEK: Right there. Documenting the health status. I believe it would be whoever prescribed, ordered the equipment. We'll get clarification.

MS. KENNY: Oh, I see. I See.

MS. PANEK: Yeah. I think we need to clarify that. So if you could put that in a question too.

MS. KINNEY: I think we did.

MS. DAVIS: Okay.

MS. CASCHETTA: This is related to 3.10 liquidated damages. Has there been, historically has there been a problem with performance under the

contract that has resulted in the State putting in these liquidated damages clauses?

MS. DAVIS: Well, we're not going to discuss our current contract. But the liquidated damages is part of the contract requirements.

MS. PANEK: It's become standard.

MS. DAVIS: Yeah. And it is actually standard in our contract now.

MS. CASCHETTA: So you had them in your contracts previously?

MS. DAVIS: Yes. Uh-huh.

MS. GRANT: Page 42 at the top, number nine, discharge planning.

MS. BAHARLOO: That's part of the acute care authorization.

MS. DAVIS: Any more questions?

(No response.)

MS. DAVIS: As I said, if you don't have any questions now and you do find that you need something clarified as this process continues you can certainly send questions to the email address listed in section

1.9. And any questions that we have received so far will be part of the minutes, and we will respond to all of them as quickly and as efficiently as possible. And any questions that we have not answered I ask that you send them to us today in writing and we will respond accordingly. Are there anymore questions?

(No response.)

MS. DAVIS: Seeing no more questions at this time, this meeting is adjourned.

MS. PANEK: We haven't covered the acute care.

MS. DAVIS: Oh, we haven't? Okay.

MS. BAHARLOO: In addition the long term care review that Jane discussed earlier, the contractor will also review the in-patient medical necessity for the acute hospitalizations for the Maryland participating enrollees. These in-patient hospital stay reviews include pre-admission for elective hospital admission reviews. Preauthorization for these services are provided by the contractor in addition to pre-authorization for procedures that are going to be

performed and also preoperative reviews are done by the contractor.

Once the patient is admitted to the hospital the contractor also does concurrent reviews, like Jane mentioned for long term care, to just confirm that the hospital stay is medically necessary. That means the patient is receiving acute level of care while they are in the hospital.

And upon discharge of the patient then the contractor does retrospective reviews. These retrospective reviews the contractor reviews the full medical records and also checks all the diagnosis codes and the services that were provided when the patient was in the hospital, and they determine which dates met the medical necessary criteria and which days they did not meet the necessary criteria.

The contractor also reviews the undocumented or unqualified alien, or we used to call them formerly known as illegal or illegal aliens in emergency admissions, to determine that the admission to the hospital for these enrollees were emergent. Only the

emergency services for this population is covered.

In addition, reconsideration reviews are performed by the contractor. Once the provider tells me that additional information and request the review, then the contractor takes in consideration the provider's information and reviews the case again to determine if the additional information criteria meets the medically necessary for that inpatient stay.

The administrative day review that you had a question regarding. If the hospital stay is not medically necessary as an acute service, then the hospital will be submitting the 1288 form with the 3808 form to request administrative day. When they are waiting for discharge or when waiting for placement then they need to be requesting the administrative day rather than acute days. And the whole time the review is also, the contractor needs to be looking at the discharge planning because as part of the hospital stay the provider needs to be always trying to find out how to discharge the client out of the hospital so the patient is not inpatient anymore than that are

necessary. So that also is part of the contractor, to review their activities for discharge planning to make sure that they went through the whole process of finding placement for the patient rather than keep them inpatient in the hospital.

I think I quickly, I gave a quick overview. So if you have any questions about the review?

MR. DORSEY: Quick question about the records. For all the review types is the contractor getting the medical records directly from the hospital or will they be coming from the State? And if they are coming from the hospital does the contractor have to pay the hospital to secure those records?

MS. BAHARLOO: All the records for review come directly from the hospital to the UCA. And it doesn't come from the State. And I don't think there is any pay.

MS. PANEK: No, there is no -- they don't charge -- hospitals don't make them pay for records.

MS. BAHARLOO: No. No.

MS. PANEK: It's in their interest to give

the UCA those records.

MS. GRANT: In the discharge planning and review process does the contractor have any responsibility of making sure that that happens or just do the review, do the findings, there's nothing else connected with that?

MS. BAHARLOO: The contractor's job is just to see if the hospital performed all the actions necessary to discharge the patient. You don't have -- the contractor does not have any responsibility to find placement or discharge the patient. You're just going to see that the hospital took all the steps necessary to discharge the patient.

MS. DAVIS: Anymore questions?

MS. GRANT: Can you say what the percentage of requests for the reviews; do they come from the mail, fax, or how does that --

MS. BAHARLOO: I think at this time most of them are coming through, there is a system. I guess mostly they would be electronic transmission. And there's going to be very low percentage at this time on

paper or CD. They mostly are electronic submission.

MS. PANEK: That would be part of the expectation I think as spelled out in the information technology requirements where the contractor would develop a system, presumably a portal of some sort. That's what the providers are used to.

MS. LEWIS: Anyone have any additional questions?

MS. GRANT: On page 40, number 4D, under concurrent review, you have emergency admissions review under concurrent review. Would we consider emergency admissions review separate from concurrent review as an entity into itself?

MS. BAHARLOO: I think the reason they're here is because after the emergency submission, then that's where concurrent review begins. So you do -- the emergency review is done, and then once the patient is admitted, then the concurrent review is performed.

MS. CASCHETTA: On section, your indemnification section three at 10.4. This is saying that the State has no obligation to I guess defend or

protect contractors in the event the contractor is sued for its performance under the contract. But if you have a medical director the medical director and physician advisors are exposed under the contract because they're going to be well known. They're going to make review decisions. If a hospital files an action, or a suit, or a class action, or whatever against the physicians or any of the parties for their decisions, whether they're right or wrong, they'll file an appeal. People do things. Does the State protect the contractor like the federal government protects its contractors? So the State does not step in and -- or do you have any laws that protect contractors from performing their --

MS. PANEK: I think -- and you've brought this up before, the notion of performance. It isn't necessarily if a hospital or another provider disagrees with the decision. That's taken care of in an appeal process that's totally outside of the UCA. I mean, the decision you're making, you're our agent. You're making a decision that is our program's decision. And

so the appeal of a recipient or a provider comes to the department and we defend that. I'm not -- I mean, we can certainly ask the legal advisors, but I have never been aware of a separate action against --

MS. DAVIS: No.

MS. PANEK: That doesn't happen. The matter is between the recipient and the program. The UCA is the agent of that. And in most cases, if not all cases of a proposed denial, we have a physician, we have physician reviewers here that will be the ultimate reviewers of that.

MS. LEWIS: Does anyone else have any questions?

MS. DAVIS: Are there anymore subjects that we need to cover?

MS. LEWIS: No.

MS. DAVIS: No more questions?

(No response.)

MS. DAVIS: Now the meeting is officially adjourned. I thank you all for coming.

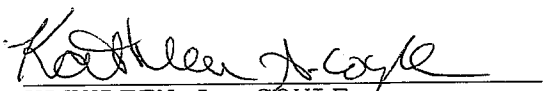
(Whereupon, at 10:10 a.m., the meeting

was adjourned.)

CERTIFICATE OF NOTARY

I, KATHLEEN A. COYLE, the officer before whom the foregoing testimony was taken, do hereby certify that the witness whose testimony appears in the foregoing transcript was duly sworn by me; that the testimony of said witness was taken by me by stenomask means and thereafter reduced to typewriting by me or under my direction; that said testimony is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this testimony is taken; and, further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of the action.

This certification is expressly withdrawn and denied upon the disassembly or photocopying of the foregoing transcript of the proceedings or any part thereof, including exhibits, unless said disassembly or photocopying is done by the undersigned court reporter and/or under the auspices of Hunt Reporting Company, and the signature and original seal is attached thereto.



KATHLEEN A. COYLE
Notary Public in and for
the State of Maryland

My Commission Expires:

April 30, 2018